UTAH MEDICAL PROGRAMS SUMMARY

UTAH DEPARTMENT OF HEALTH

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www.health.utah.gov/medicaid

Information in this document is provided as a public service to community agencies. The summary is designed to give a broad overview of the programs and should not be used to determine eligibility.

BUREAU OF ELIGIBILITY POLICY (BEP)
DEPARTMENT OF WORKFORCE SERVICES (DWS)
Medical Programs Summary

Medical assistance is available to U.S. citizens and resident aliens who meet Utah residency and specific non-financial and financial criteria. This booklet does not explain all of the eligibility criteria. Please contact a Medicaid Eligibility Worker if you have questions about qualifying for Medicaid or any medical assistance program.

Terms You Should Know

- **Assets:** Generally, any type of "property", such as cash, items easily turned into cash, and other non-cash property including bank accounts, cash on hand, vehicles or vacation homes. Each program has its own rules about counting assets. Some assets are not counted because a person would reasonably need them for normal living - for example, **Medicaid programs do not count the home a family lives in as an asset.**

- **Deductions:** Amounts subtracted from gross income before comparing it to the applicable income limit.

- **Disregard**: A disregard is either income or assets that we do not count to decide eligibility.

- **Health Plan:** A medical provider network responsible for recruiting and paying the actual medical providers. Most Medicaid recipients must enroll in a Health Plan. Recipients can select a primary doctor from among the Health Plan's providers. The Health Plan must approve some types of services before the recipient receives it. Recipients must have a referral from the Health Plan to seek services from a provider who does not belong to the Health Plan.

- **Income:** Any kind of money coming into the household such as wages, child support, interest from investments or bank accounts, Social Security.

- **Liens:** The State has a right to recover from the recipient's estate all Medicaid funds spent on behalf of a recipient who is 55 years of age or older if all of the following conditions are met:
    1. There is no surviving spouse.
    2. There are no surviving children under age 21.
    3. There are no surviving blind or disabled children.

  ORS may waive estate recovery when the property is the sole income producing asset and source of support for the survivors. Anyone can apply for an undue hardship consideration for other circumstances. You are not required to sign a lien when you apply for Medicaid. A lien is placed on real property only after death. For more information see the pamphlet "Estate Recovery Information Bulletin", DWS 05-994.

- **Medical bills as deductions:** Medically necessary services for a family member that the family must pay. The bill must either be unpaid, or the family must have received and paid for the service in the retroactive coverage period or application month. Bills may be used as a deduction from income only for certain Medicaid programs.

- **MWI Premium**: The cost sharing responsibility of a disabled person who is eligible for the Medicaid Work Incentive Program. The MWI premium must be paid with cash or check. DWS cannot accept payment of an MWI premium from a Medicaid provider. DWS will accept payment if the provider is your representative payee and the payment is made with your funds.

- **Prior-authorization:** Medicaid requires some medical services to be approved by the Division of Medicaid and Health Financing or by the Health Plan provider before they are given. If the Medicaid client has the service without getting it authorized, neither the Division of Medicaid and Health Financing nor the Health Plan will pay the bill.

- **Retroactive coverage:** Receiving medical coverage for a past period. Medicaid programs allow the person to request coverage for three months prior to the date of application. The Qualified Medicare Beneficiary program and the PCN program do not allow retroactive coverage.

- **Spenddown:** A way for clients who have income greater than the income limits for a Medicaid coverage group to "buy" Medicaid coverage. The client either pays cash or submits medical bills equal to the spenddown amount. The spenddown is the difference between the client's countable income and the medically needy income limit. Not all medical programs allow clients to spenddown to become eligible. DWS cannot accept payments of a spenddown from a Medicaid provider.

- **Payments to Be Eligible:** If you owe a spenddown or other fee to receive medical assistance, you must pay such amount to DWS to be eligible. DWS cannot accept payments from Medicaid providers for your spenddown or other fee that you owe. DWS will accept payments if the provider is your representative payee and the payment is made with your funds.

- **Traditional Medicaid, Non-Traditional Medicaid & PCN:** Determines the benefits the eligible individual receives.
  Card Colors: A purple card indicates Traditional Medicaid, a blue card indicates Non-Traditional Medicaid and a yellow card indicates eligibility for the PCN program.

MEDICAID PROGRAMS

LIFC Family Medicaid

LIFC Family Medicaid provides coverage for low income families with dependent children. Families must meet a deprivation of support requirement. This means the children must be deprived of parental support due to the death, absence, or incapacity of a parent. Families meet deprivation when the primary wage earner is unemployed or employed less than 100 hours per month. The household must pass two specific income tests. Households receiving LIFC may qualify for a 12 month earned income disregard when they lose eligibility because the earned income of a parent exceeds the income limit (LIFC-12 Month Disregard). Additionally, LIFC households may qualify for LIFC-4 Month Extended or LIFC-12 Month Transitional Medicaid when they lose eligibility for LIFC due to child support collections or earnings of a parent.

Income Tests: The Income limit depends on household size, the Federal Poverty Level (FPL) and/or the Basic Maintenance Standard (BMS) level. (Both the FPL and BMS are set by the US Federal Government.) See https://utahcares.utah.gov/infosourcemedicaid/ ,Table VII for the income limit of a specific household size.

Deductions: No deductions are allowed in the first income test.
Second test: $90.00 work allowance, $30 and 1/3 disregard*****, and child care ($200 maximum per child under age two, $175 over age two) from earned income.

*****Each individual with earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Spend down: Not allowed.

Asset Limit: 1 person - $2,000 2 people - $3,000 Each additional person add $25

Retroactive coverage is allowed.

Medically Needy Family Medicaid

This program provides Medicaid coverage to low income families who do not qualify for LIFC because of income or other household circumstances. The household must meet the same deprivation of support requirement as the LIFC program described above. The differences between the LIFC and the medically needy family program are that medically needy family households do not have to meet the gross income test. They may spend down to the income limit to be eligible; and they may voluntarily choose to leave a child out of the coverage when they do not want to count the child's income or resources in determining eligibility. Families must include at least one eligible child in the coverage to qualify for the Medically Needy Family Program. Medically Needy Family households are not eligible for the LIFC-12 Month Disregard or for the LIFC-12 Month Transitional Medicaid programs.

Income Test: The income limit depends on household size, the Federal Poverty Level (FPL) and/or the Basic Maintenance Standard (BMS) level. (Both the FPL and BMS are set by the US Federal Government.) See https://utahcares.utah.gov/infosourcemedicaid/ ,Table VII for the income limit of a specific household size.

Deductions: $90.00 work allowance, a $30 and 1/3 disregard*****, child care ($200 maximum per child under age two, $175 over age two) from earned income; health insurance premiums; some medical bills.
*****Each individual with earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Spend down: Allowed.

Asset Limit: 1 person - $2,000 2 people - $3,000 Each additional person add $25

Retroactive coverage is allowed.

LIFC-4 Month Extended
&
LIFC-12 Month Transitional Medicaid

Families who become ineligible for LIFC Family Medicaid may receive additional months of Medicaid coverage depending on the reason they became ineligible. Families who are no longer eligible for LIFC because of increased child or spousal support can receive Medicaid for 4 additional months (LIFC-4 Month Extended). Families who are no longer eligible for LIFC because of increased earnings, increased hours of employment of the parent or non-parent specified relative, or because of the loss of LIFC time limited income disregards can receive up to 12 months of continued Medicaid coverage (LIFC-12 Month Transitional). A household must meet certain income and reporting requirements to qualify for LIFC-12 Month Transitional Medicaid.

Non-Parent Caretaker Relative (LIFC or Medically Needy Family)

An adult who is caring for a relative child, but is not the parent of the child, may qualify to receive Medicaid. The adult must meet the Family Medicaid eligibility criteria except for deprivation. The caretaker relative's spouse and dependent children cannot be included on the program unless they meet deprivation. Income and assets of the excluded spouse of a caretaker relative must be counted. A different income calculation is used to determine countable income. Spenddown and retroactive coverage is allowed. Transitional Medicaid is available if all criteria are met.

Pregnant Woman

The Prenatal Woman program provides full Medicaid coverage to pregnant women. The income limit for this program is 133% of the Federal Poverty Level for the household size. The program covers the mother from application through 60 days after the birth of her child. Once eligible, the woman remains eligible for the entire period. **Children born to women on the Pregnant Woman program can receive Medicaid through the month of their first birthday under the Child Under Age 1 program.**

Income Test: 133% of the Federal Poverty Level

Deductions: $90.00 work allowance, $30 and 1/3 disregard*****, and child care ($200 maximum per child under age two, $175 over age two) from earned income.
*****Each individual with earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Asset limits: $5,000. Household's whose assets exceed the $5,000 limit may pay a co-payment equal to 4% of the **total** assets. The maximum co-payment is $3,367.

Retroactive coverage is allowed.

Medically Needy Pregnant Woman

This program covers pregnant women who do not meet the income limits for the Pregnant Woman program. The advantage of the Medically Needy Pregnant Woman program is that a woman may pay a spenddown and receive the coverage. Eligibility follows the regular Medically Needy Family program except that the household does not have to meet deprivation of support requirements. The woman may receive 60 day postpartum coverage if she applies for benefits before the birth of the child. Spenddown is allowed and must be met for each month of coverage including the 60 day postpartum period. The child will qualify for Medicaid for the first year under the Child Under Age 1 program with no spenddown.

Child Under Age 1

This program covers the newborn from birth to twelve months and the mother for the 60 day postpartum period. If the mother qualifies for the Pregnant Woman program, the 60 day postpartum coverage for the mother and child is automatic. Mothers who were not on Medicaid when the baby was born may apply after the birth. If she is determined eligible for the Pregnant Woman program back to the date of the infant's birth, she will also receive the 60 days postpartum coverage and the baby will receive the one year of coverage.

At the end of the 60 day postpartum period, the household must provide verification of the birth and information about any possible insurance coverage for the child. Application for a Social Security card will be requested, but isn't required.

Child Age 0-5

This program provides Medicaid coverage for children from birth through the month the child turns age 6. Children do not have to be deprived of parental support as in the LIFC and Medically Needy Family programs. A child does not have to reside with a relative to receive coverage.

Income Limit: 133% of the Federal Poverty Level (Same as Pregnant Woman program).

Deductions: $90.00 work allowance, $30 and 1/3 disregard*, and child care ($200 maximum per child under age two, $175 over age two) from earned income. *****Each individual with earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Spend down: Not allowed.

Asset limits: None.

Retroactive coverage is allowed.

Child Age 6-18

This program provides Medicaid coverage for children from age 6 through the month they turn 19*. Children do not have to be deprived of parental support and do not have to reside with a relative to receive coverage. The income limit for this program is 100% of the Federal Poverty Level for the household size.

Income Test: 100% of the Federal Poverty Level

Deductions: $90.00 work allowance, $30 and 1/3 disregard, and child care ($200 maximum per child under age two, $175 over age two) from earned income. *****Each individual with earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Spend down: Not allowed.

Asset limits: Same as regular Medically Needy Family.

Retroactive coverage is allowed.

Medically Needy Child

Children in households that do not meet the LIFC deprivation of support requirements and whose income exceeds the Child Age 0-5 or Child Age 5-18 Medicaid limit may be eligible for the Medically Needy Child program. Children must be under age 18 or between age 18 and 19, in school and expected to graduate before turning 19. Children do not have to be living with a relative. The income and assets of adult household members who are not the parents of the child are not counted. All other eligibility factors follow the guidelines under the Medically Needy Family program.

Refugee Medical Assistance

Refugees entering the United States are eligible to apply for and receive Medicaid for 8 months after their date of entry. The same income and resource standards apply as for LIFC Medicaid. Refugee Financial Assistance automatically provides eligibility for Refugee Medical.

Medicaid Cancer Program

The Medicaid Cancer program provides full Medicaid benefits to uninsured women under age 65 who have been screened for breast or cervical cancer under the CDC (Center for Disease Control) Breast and Cervical Cancer Early Detection Program and are found to need treatment for either breast or cervical cancer, including pre-cancerous conditions and early stage cancer. The Utah Cancer Control Program (UCCP) is the CDC provider that will complete the screening. If a woman has another type of cancer but the primary cancer is breast or cervical cancer, they may still meet the requirement. A woman who is diagnosed with a precancerous condition can only receive Medicaid for three months under the Cancer program.

A woman must meet the general Medicaid requirements along with the following requirements:

- Screened by the UCCP
- Need treatment for breast or cervical cancer or a precancerous condition
- Cannot be eligible for any other Medicaid program unless a spenddown, premium or asset co-pay is required to qualify
- Have no creditable health insurance coverage which covers treatment of breast or cervical cancer
- Must be under the age of 65

Income Test: There is no income limit after meeting the income test of the UCCP.

Asset limits: None.

Retroactive coverage is allowed but not prior to the woman being screened by UCCP. The UCCP toll free referral number is 1-800-717-1811.

Foster Care Medicaid (Title IV-E)

The Foster Care Medicaid Program (Title IV-E) provides full Medicaid coverage to children: (1) who are in the custody of an agency within the Department of Human Services (DHS), (2) for whom a foster care maintenance payment is being made by DHS, and (3) who meet eligibility and reimbursement requirements for Title IV-E, as determined by DHS.

A child may continue to qualify for this program until age 18. A child between age 18 and 19 may qualify until the month of graduation if attending school full time and expects to graduate before the child's 19th birthday.

An extension for Medicaid coverage to age 21 is available for children aging out of foster care if they receive Independent Living Services through DCFS.

Income, asset and deprivation factors are as defined in the State's AFDC plan effective on July 16, 1996, except as amended by subsequent Federal Title IV-E legislation. Retroactive coverage is allowed to the date of the child's removal from the home when entering state custody.

Foster Care Medicaid (Non IV-E)

The Foster Care Medicaid program (Non IV-E) provides full Medicaid coverage to children: (1) who are in the custody of DHS, (2) for whom a foster care maintenance payment is being made by DHS, (3) who do not meet eligibility or reimbursement requirements for Title IV-E, as determined by DHS, and (4) who meet the requirement for another Medicaid program applicable for children.

Income, assets, and other eligibility factors are as defined for other existing child Medicaid programs such as Child Age 0-5, Child Age 6-18, Disabled Medicaid, or Medically Needy Child. Continuing qualification is based on the criteria for the specific program each child qualifies under. Retroactive coverage is allowed to the date of the child's removal from home when entering state custody.

Custody Medical Care (MI-706)

The Custody Medical Care program enables children entering foster care to immediately access health care services. The program is for foster children who have not yet had Medicaid eligibility determined, who do not qualify for any Medicaid eligibility while in custody, or who need health care services not covered by Medicaid. The program is paid for with State general funds.

This program has no income, asset, or deprivation tests. The program can be authorized by DHS or a DOH Fostering Healthy Children Program Nurse for each foster child. A child may qualify for this program until state custody is discontinued.

Subsidized Adoptions

A subsidized adoption refers to the adoption of a child with special needs where an adoption assistance agreement is established between the adoptive parents and a state or local government agency. The adopted child may qualify for either Title IV-E or State Adoption Assistance. A child who has an adoption assistance agreement in effect with a state or local government agency is eligible to receive Medicaid. It does not matter if the child is receiving a monthly cash subsidy. **There is no income or asset test for this type of Medicaid.**

The adoption assistance agreement usually ends the month that the child turns 18. However, the adoption assistance may extend through the month in which the child turns 21 if the child is determined to be physically, mentally or emotionally disabled by the agency originating the adoption assistance agreement. Subsidized Adoption Medicaid ends at the end of the month the adoption assistance agreement ends.

Baby Your Baby

Baby Your Baby is a type of temporary medical coverage for pregnant women who are determined presumptively eligible. Coverage begins the same day client is found eligible for the program by the qualified health care provider that makes the presumptive decision. This eligibility lasts only until the last day of the next month or until Medicaid makes a determination regarding the client's eligibility, whichever occurs first. The woman needs to apply for regular Medicaid before the presumptive period ends. Only one Baby Your Baby Presumptive Eligibility Card can be issued per pregnancy so it is important to apply for Medicaid as soon as possible.

This card covers **outpatient pregnancy related services** while the Medicaid application is processed. If the applicant is determined eligible for Medicaid, the Medicaid card will cover the rest of the pregnancy along

with other Medicaid covered services. The infant does not qualify for the one year of coverage if the mother is only eligible under the Baby Your Baby program and does not subsequently become eligible for Medicaid.

To sign up for Baby Your Baby medical assistance, the pregnancy must be confirmed with a test by a doctor or clinic.

Income Limit: 133% of the Federal Poverty Level.

Deductions: None calculated for the Baby Your Baby Card

Assets: None

Retroactive coverage is not allowed.

Children's Health Insurance Program (CHIP)

CHIP is a state health insurance plan for children who do not have other health insurance and do not qualify for Medicaid. Many children who qualify for CHIP come from working families. Depending on income and family size, uninsured Utah families may qualify. For example, a family of four earning up to $44, 100 a year may be eligible. Once approved, CHIP covers well-child exams, immunizations, dental care, hearing and eye exams, and more. Depending on income, families may pay up to $75 every three months, as well as small co-pays for services like a visit to the doctor.

Enrollment is now always open. Families can call 1-877-KIDS-NOW (1-877-543-7669) for an application, apply online at www.health.utah.gov/chip, or apply in person at a local Department of Workforce Services office.

Age Requirement: Under age 19

Citizenship: Only the child needs to be a U.S. citizen or legal resident

Income limit: 200% of the Federal Poverty Limit for household size. No deductions are allowed.

Assets: No asset limits

Retroactive coverage is not allowed.

Primary Care Network (PCN)

PCN is primary preventive health coverage for uninsured adults who do not qualify for Medicaid and do not have access to any other health insurance. PCN benefits include physician services, prescriptions, dental services, eye exams, emergency room visits, emergency medical transportation, birth control and general preventive services. Depending on income, adults may pay up to $50 per year for an annual enrollment fee, as well as low co-pays for services like a visit to the doctor.

Applications are only accepted during open enrollment periods. For an application or more information visit www.health.utah.gov/pcn, call the PCN hotline at 1-888-222-2542 or apply in person at a local Department of Workforce Services office.

Age Requirement: 19 through 64

Citizenship: U.S. citizen or legal resident

Income limit: 150% of the Federal Poverty Level for household size. No deductions are allowed.

Additional Requirements: Do not qualify for Medicaid or have access to student health insurance, Medicare or Veterans Benefits.

Assets: No asset limits

Retroactive coverage is not allowed.

Utah's Premium Partnership for Health Insurance (UPP)

UPP (pronounced "up") helps uninsured, working individuals and families pay their monthly health insurance premiums. If an employee's company offers health insurance, qualified individuals and families will receive monthly reimbursements for the cost of their employer-sponsored health insurance coverage. If qualified, UPP will pay up to $150 per adult and up to $100 per child each month. UPP is for those that do not qualify for Medicaid, have access to health insurance through their employer and have not yet enrolled in their employer-sponsored health plan.

For an application or more information, call 1-888-222-2542, visit www.health.utah.gov/upp, or apply in person at a local Department of Workforce Services office.

Age requirement: Under age 65

Citizenship: U.S. citizen or legal resident

Income limit: **Adults:** 150% of the Federal Poverty Limit for household size. No deductions are allowed.
Children: 200% of the Federal Poverty Limit for household size. No deductions are allowed.

Additional Requirements: Do not qualify for Medicaid and do not have access to Medicare or Veterans Benefits.

Assets: No asset limits

Retroactive coverage is not allowed.

Aged, Blind, Disabled Medical

This program provides Medicaid for individuals who are Aged (65+), Blind, or Disabled. People under age 65 must meet the Social Security criteria for being blind or disabled. Receipt of SSI or SSA disability benefits meets the criteria for disability. If the individual is not on SSI or SSA disability benefits, the State Medicaid Medical Review Board may make a disability decision. If Social Security has not denied disability based on medical evidence, the State Medicaid Medical Review Board can determine disability without considering substantial gainful employment.

If the person receives SSI, we do not count income of a spouse or parent; however, assets of a spouse or parent are counted. The SSI person's income doesn't count toward the income limit except for Nursing Home or Home and Community Based Waiver clients. Some individuals who lose their SSI payments may still qualify without a spenddown under one of the SSI protected groups.

Income: 100% of the Federal Poverty Level

Deductions: $20.00 general income exclusion, the first $65.00 and then ½ of earned income that remains, impairment related work expenses, health insurance premiums, and some medical bills.

Spend down: Allowed.

Asset limits: 1 person - $2,000 2 people - $3,000

Retroactive coverage is allowed.

Medicaid Work Incentive (MWI) Program

MWI is a Medicaid program for persons who meet the Social Security criteria for disability and have earned income. The household income limit is 250% of the Federal Poverty Level. If household net income does not exceed 100% of the Federal Poverty Level, the individual will not pay an MWI premium. If household net income is above 100% of the Federal Poverty Level, but below the 250% of the Federal Poverty Level, the individual will pay a MWI premium.

Income Test: Only the income of the client, a spouse living in the home and income of parents of a minor client will be counted and compared to the 250% of the Federal Poverty Level.

Deductions: $20 General income disregard; the first $65 of earned income and ½ of the remaining; impairment related work expenses. Allocations for children or parents are not allowed. A spouse's income does not have to exceed the allocation to be counted in the 250% test.

MWI Premium: Countable income is calculated the same way it is for the 100% A&D poverty group. **Only the countable income of the disabled wage earner is used to determine the premium amount**. The MWI premium is calculated as follows:

Countable Income Is	Multiply Income By
More than 100% but not over 110% of FPL	5%
More than 110% but not over 120% of FPL	10%
Over 120% of FPL	15%

The MWI premium must be paid in cash (check, money order, credit/debit card.) DWS cannot accept payment of an MWI premium from any Medicaid provider.

Asset Limit: $15,000 for all household sizes. Certain retirement accounts are exempt.

Retroactive Coverage is allowed.

Emergency Medicaid

Emergency Medicaid is not a different Medicaid program. It refers to coverage for individuals who meet all of the other eligibility criteria for one of the Medicaid programs, but who are not U.S. citizens or qualified resident aliens. It only covers emergency medical services. Coverage is provided for the month the emergency occurs and is not provided ongoing. Pregnant women can apply one month before the expected date of delivery and receive coverage for the labor and delivery charges. Emergency Medicaid does not cover nursing home or other long-term care services, and is not available for Medicare Cost-Sharing Programs, CHIP or PCN. An infant born to a woman eligible for emergency Medicaid is eligible for Medicaid through the month of the baby's first birthday.

MEDICARE COST-SHARING PROGRAMS

There are three Medicare cost-sharing programs for people with Part A Medicare. These programs help cover some of the recipient's costs for Medicare services. They are not Medicaid programs, but a Medicaid recipient who has Part A Medicare may be eligible for both Medicaid and either QMB or SLMB coverage. Qualifying Individuals (QI) benefits are only available to people who are not on Medicaid. About three months after becoming eligible for a Medicare cost-sharing program, the state begins paying the Medicare Part B premium and the Social Security check will increase. However, recipients will be reimbursed by Social Security for each month of eligibility during which a Medicare premium was deducted from the person's check.

Qualified Medicare Beneficiaries Program (QMB)

The QMB program pays Medicare premiums and copayments for low-income **Medicare** recipients. People who receive, or are eligible to receive, Part A Medicare may apply for QMB. QMB pays Medicare Part B premiums, deductibles, and Part A and Part B co-payments. It can also pay Part A premiums. Coverage begins the first of the month following the month the client is determined eligible. A card will be issued each month. If the individual does not receive Medicaid, the card will read "MEDICARE COST-SHARING ONLY." Otherwise, the card will look like a regular Medicaid card.

Income limits: 100% of the Federal Poverty Level

Deductions: $20.00; $65 of earned income and ½ of remaining earned income.

Spend down: Not allowed.

Asset limits: 1 person - $6600 2 people - $9910

Retroactive coverage is not allowed.

Specified Low-Income Medicare Beneficiaries (SLMB)

The SLMB program pays the Part B Medicare premium only. Part B Medicare covers a person's physician care, and a variety of out-patient services including out-patient hospital services. Applicants must pass all the QMB rules, except that they must be receiving Part A coverage and their income exceeds 100% of the Federal

Poverty Level and does not exceed 120% of the Federal Poverty Level. No card is issued for the SLMB program. An individual may be eligible for both Medicaid and SLMB.

Income limits: 120% of the Federal Poverty Level

Deductions: $20.00 general income exclusion, the first $65.00 and then ½ of earned income that remains

Asset limits: 1 person - $6600 2 people - $9910

Retroactive coverage is allowed.

Qualifying Individuals (QI)

The QI program pays the Part B Medicare premium. Applicants must pass all the QMB rules except that they must be receiving Part A Medicare and their income exceeds 120% of the Federal Poverty Level but not more than 135% of the Federal Poverty Level, and the individual **cannot** be receiving Medicaid. This is not an entitlement program. States have been granted a set amount of federal money to cover the benefits paid by the QI program. When funds have been allocated for a calendar year, no new applicants will receive any benefits. Eligibility in future calendar years is not guaranteed. No card is issued for the QI program.

Income limits: 135% of the Federal Poverty Level

Asset limits: 1 person - $6600 2 people - $9910

Retroactive coverage is allowed.

MEDICAID FOR LONG-TERM CARE

To get Medicaid to pay for long term care, people must be financially and medically eligible. The individual may enter a medical facility such as a nursing home, or may be able to receive care in his or her own home under one of the home and community based waivers. Space is limited in home and community based waivers and may not be available in all areas. Home and community based waivers allow Medicaid to pay for some specialized services that would not otherwise be covered by Medicaid in community settings.

Nursing Home (NH)

Nursing home Medicaid will pay for nursing home and other medical costs. Some different income and asset rules apply for married couples. An individual must meet medical criteria for nursing home level of care to be eligible for Medicaid in a nursing facility.

Income limits: Complicated. For single people, income deductions are different if they will be there less than six months. A long-term nursing home resident is able to keep $45 of monthly income for their personal needs. The rest of the money, in most cases, must be paid to the nursing home.

Supplemental income: SSI recipients in nursing homes receive an SSI payment of $30 a month plus a state supplemental payment of $15.

Deductions:	Complex. Under Spousal Impoverishment, a spouse at home may be allowed to keep a portion of the income of the nursing home resident for living expenses. Medical insurance premiums are an allowable deduction.
Spend down:	Allowed. It is considered a contribution to care and is paid to the nursing home.
Asset limits:	Complex. Under Spousal Impoverishment law, the nursing home resident is allowed $2,000.00. Subject to certain limits, the spouse at home may keep ½ the total amount of countable assets that the couple owned when the patient entered the nursing home. These limits go up January 1st of each year. Clients must report all annuities in which the client or spouse have an interest. Annuities must name the state as the beneficiary upon the death of the client.
Transfer of Assets:	Transfers of assets for less than the fair market value can result in the person being ineligible (i.e., penalized) for nursing home Medicaid services for a period of time. When an application for Medicaid is made, the eligibility worker will ask for information from the prior 60 months about what the person has done with assets. This is called the look-back period.
Substantial Home Equity:	If a person has equity value in his or her home of $500,000 or more, the person is ineligible for Medicaid coverage of the nursing home charges.

Retroactive coverage is allowed for nursing home charges only from the date the patient is determined medically eligible. Ancillary (non nursing home) charges are allowed.

For more information request the pamphlet "Nursing Home Information, May we be of service to you?" DWS 05- 969. For Married couples also request, "Assessment of Assets" DWS 05-992.

Aging Home and Community Based Waiver

This waiver is a special program for clients who would be medically appropriate for institutional care. These clients are eligible for medical services that are not generally available to Medicaid recipients in community settings such as day treatment programs, lifeline, and in-home respite care. To be eligible for this program, recipients must be at least 65 years old. The referral process begins with the Area Agency on Aging (AAA). A case manager from AAA must complete an evaluation of the individual's appropriateness for the waiver.

Income limits: 100% of the Federal Poverty Level (adjusted annually). Only the waiver client's income counts.

Deductions:	$125 earned income deduction; spousal and family allowance; health insurance premiums; medical expenses; some shelter costs.
Spend Down:	Allowed
Asset Limits:	Complex. $2000; same spousal impoverishment rules as Nursing Home.
Transfer of Assets:	Same as Nursing Home. Waiver services will not be paid during a penalty period.

Retroactive coverage is allowed. However, Waiver services received prior to the date the person met the medical criteria, as certified by the AAA worker, cannot be paid.

Substantial Home Equity:	If a person has equity value in his or her home of $500,000 or more, the person is ineligible for Medicaid coverage of waiver services.

Utah Community Supports Waiver

This waiver is a special program that helps severely disabled people of any age remain in their homes rather than be institutionalized. Applications are taken through the Division of Services for People with Disabilities (DSPD). Parent's income and assets are not counted in determining a minor child's eligibility. Also, an intensive service plan is drawn up for the client. To be eligible for this program, clients must have been disabled before age twenty-two.

Income limits: 100% of the Federal Poverty Level (adjusted annually)

Deductions : Earned income deduction equal to SSA's substantial gainful activity level; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.

Spend down: Allowed.

Asset limits: Complex. $2000; same spousal impoverishment rules as Nursing Home

Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a penalty period.

Substantial Home Equity: If a person has equity value in his or her home of $500,000 or more, the person is ineligible for Medicaid coverage of waiver services.

Retroactive coverage is allowed. However, Waiver services received prior to the date the client met the medical criteria, as certified by DSPD, cannot be paid.

Technology Dependent Children Waiver

A special program which helps medically fragile children remain in their home rather than be institutionalized. Children can qualify for this waiver through the month in which they turn 21. Recipients 21 and older who are admitted to the waiver prior to their 21st birthday may receive ongoing benefits. Applications are taken through the Division of Family Health Services. Parent's income or assets are not counted towards the child's eligibility. An intensive service plan is drawn up for the client and parents receive specialized training in how to provide some of the care the child needs. Families usually receive private-duty nursing services due to the complex medical condition of these children. To be eligible for this program, clients must meet specific medical criteria.

Income limits: 100% of the Federal Poverty Level (adjusted annually)

Deductions : $125 earned income deduction; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.

Spend down: Allowed.

Asset limits: Complex. $2000; same spousal impoverishment rules as nursing home.

Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a penalty period.

Substantial Home Equity: If a person has equity value in his or her home of $500,000 or more, the person is ineligible for Medicaid coverage of waiver services.

Retroactive coverage is allowed. However, Waiver services received prior to the date the client met the medical criteria, as certified by the Division of Family Health Services cannot be paid.

Brain Injury Waiver

This waiver is a special program for clients who have a brain injury and would be medically appropriate for institutional care. These clients are eligible for medical services that are not generally available to Medicaid recipients in community settings such as supported employment, day treatment programs, behavioral training, and in-home respite care. Policy follows the institutional policy except that the client is allowed higher income deductions. Applications are taken through the Division of Services for People with Disabilities (DSPD).

Income limits:	100% of the Federal Poverty Level (adjusted annually) Only the waiver client's income is counted.
Deductions :	$125 earned income deduction; some shelter expenses; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.
Spend down:	Allowed.
Asset limits:	Complex. $2000; same spousal impoverishment rules as Nursing Home.
Transfer of Assets:	Same as Nursing Home Medicaid. Waiver services will not be paid during a penalty period.
Substantial Home Equity:	If a person has equity value in his or her home of $500,000 or more, the person is ineligible for Medicaid coverage of waiver services.

Retroactive coverage is allowed but not prior to the date the client met the medical criteria.

Physical Disabilities Waiver

Clients who are eligible for this waiver would be medically appropriate for institutional care. Additional services the waiver may provide include: personal care assistance, consumer training, and personal emergency response services. Policy follows the institutional policy except that the client is allowed higher income deductions. Applications are taken through the Division of Services for People with Disabilities (DSPD).

Income limits:	300% of the SSI rate. If income exceeds the 300% of SSI rate, the person must spend down to the BMS and follow DM income policy. Only the waiver client's income is counted.
Deductions:	If income is below 300% of the SSI rate, all income is deducted. If over 300%, deductions are the same as DM program.
Spend down:	Allowed when income is over 300% of SSI.
Asset limits:	Complex. $2000; same spousal impoverishment rules as Nursing Home.
Transfer of Assets:	Same as Nursing Home Medicaid. Waiver services will not be paid during a penalty period.

Substantial Home Equity: If a person has equity value in his or her home of $500,000 or more, the person is ineligible for Medicaid coverage of waiver services.

Retroactive coverage is allowed. However, waiver services received prior to the date the client met the medical criteria, as certified by the DSPD worker, cannot be covered.

New Choices Waiver

The New Choices Waiver provides home and community based services in community settings for eligible clients who require the level of care provided in a nursing facility. The primary goal of the NCW is to move people out of institutional care to a less restrictive community care setting.

To be eligible for the NCW, an individual must be age 65 or older, or must be age 21 through 64 and meet SSA disability criteria. Individuals must then meet the criteria for one of the eligibility coverage groups listed below.

- SSI recipients
- SSI Protected Group individuals: 1619(a) and (b); Adult Disabled Child; Disabled Widows/Widowers; Pickle Amendment
- 100% FPL Aged and Disabled (not spenddown clients)
- Medicaid Work Incentive
- Special Income Group (income not over 300% of the SSI Rate. Income is not deemed from a spouse; resources follow institutional resource rules)
- Spenddown Waiver Group - for individuals who cannot qualify under any other group (income is not deemed from a spouse; resources follow institutional resource rules)

Transfer of Assets: Same as Nursing Home Medicaid and apply to individuals eligible under the Special Income Group. Waiver services will not be paid during a penalty period.

Substantial Home Equity: If a person has equity value in his or her home of $500,000 or more, the person is ineligible for Medicaid coverage of waiver services.

Retroactive coverage is allowed.